NATIONAL HEALTH SERVICE CORPS
Private Practice Option Application

Name:	Work Telephone:
Mailing Address:	Home Telephone:
	Other Telephone:
	Social Security No.:

☐ Scholar ☐Loan Repayor | ☐ Currently Serving NHSC Commitment ☐**Not** Currently Serving NHSC Commitment

Profession: ☐ Physician ☐Dentist ☐ Nurse Practitioner ☐ Certified Nurse Midwife ☐ Physician's Assistant

Specialty: ☐ Pediatrics ☐ Internal Medicine ☐ Family Medicine ☐ OB/GYN ☐ Psychiatry ☐ Other (specify)

Practice Information

Proposed Practice Name:	Office Telephone
Street Address:	
City, State, ZIP:	

Practice Type: ☐ Solo ☐Group ☐Other **Ownership**: ☐ Private ☐ For-Profit ☐ Private Nonprofit ☐ Public

Full-Time Clinical Practice

Requirement: "Full-time clinical practice" is defined as a minimum of 40 hours per week at the approved service site listed (including not more than 8 hours per week devoted to practice-related administrative activities). For all physicians except obstetricians/gynecologists, family practice (FP) who do continuously do obstetrics and certified nurse midwives (CNM) at least 32 of the minimum 40 hours per week must be spent providing clinical services in the practice setting at the office specified in the written PPO Agreement. For obstetrician/gynecologists, FP physicians who continuously do obstetrics and CNMs, the majority of the 40 hours per week (not less than 21 hous per week) must be spent providing ambulatory care services at the site specified in the written PPO Agreement. Work may be compressed into no less than 4 days per week with no more than 12 hours of work to be performed in any 24-hour period. Time spent "on call" will not count toward the 40-hour week.

All providers complete the following by entering the numbers of hours per week.		**Period of Obligated Service**		**Health Professional Shortage Area**
Office-based care		Number of years obligated to NHSC		Name of geographic area, population group, or facility applicant proposes to serve (include name of County nd HPSA ID #):
Hospital inpatient care				
Administration		Anticipated starting date		
Other				
Total		Anticipated starting date		

Licensure

We cannot conclude your PPO Agreement until you are licensed to practice your profession in the State in which you will practice under the Agreement. Please attach a copy of your professional licenses or describe your plans to obtain such licensure:

Charges for Services

If this application is approved, a written PPO Agreement will be executed setting forth the terms and conditions of the practice. This Agreement will include requirements that:

(a) you provide health services at no charge, or at a nominal charge, to those persons unable to pay for services (for those whose income does not exceed 200 percent of the poverty level). Persons must be charged for services where payment will be made by a third party authorized or under legal obligation to pay the charges;

(b) you will not discriminate against any person receiving health services because of (1) inability to pay for the services, or because (2) payment for health services will be made under the Medicare or Medicaid Programs;

(c) you will accept assignment as full payment for all services under Part B of the Medicare Program;

(d) you will execute an agreement with the State agency which administers the Medicaid Program to provide medical assistance to individuals entitled to services under the State plan;

(e) your fee schedule for all billable services will be comparable to the usual and customary rate prevailing in the health professional shortage area; and

(f) you will notify patients of the terms and conditions of your PPO Agreement (this information must be prominently displayed in the waiting room).

Please describe below or on separate sheets how you plan to comply with these requirements:

(a) _____

_____

(b) _____

_____

(c) _____

(d) _____

_____

(e) _____

_____

(f) _____

_____

Verification of Employment

If you will be employed by an individual or organization under the Agreement, please attach a letter from the individual/organization verifying such employment or offer of employment.

Additional Information

You are to attach copies of the following from the State in which the practice is being located and any additional information you feel would be appropriate, to the regional office, in the review of your PPO Application: discount or sliding fee scales, letters of acceptence from Medicare and Medicaid programs with an identification number, statement from the Drug Enforcement Agency with an identification number, letter(s) from hospital(s) giving hospital priileges.

Periodic Inspections

Under the terms of the PPO Agreement, the Secretary of Health and Human Services has the authority to require semiannual reports from the PPO provider and to have NHSC representatives conduct periodic inspections of the private practice.

PPO Agreement

If your PPO Application is approved, you must enter into a written Agreement with the Secretary of Health and Human Services setting forth the terms and conditions summarized above and described in the *Private Practice Option Information Bulletin.*

I certify that the information given in this application is accurate and complete, to the best of my knowledge and belief. I understand that it may be investigated and that any intentional misrepresentation is sufficient cause for rejection of this application.

_____ _____

Signature *Date*

Send this PPO Application to:

National Health Service Corps
5600 Fishers Lane, Mail Stop 8A-55
Rockville, Maryland 20857

04/04